

# 5 . Consumer Information Under Increased Competition

For the general run of consumer goods, the buyer is necessarily an amateur while the seller is a professional.

—Joan Robinson  
*The Economics of Imperfect Competition*

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# Consumer Information Under Increased Competition

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A common desire of proponents of increased competition is that consumer preferences guide the delivery of medical care. In an environment of competition among comprehensive care organizations, consumer choice could be exercised through selection of a health plan in which to enroll. In an environment with greater patient cost sharing, consumers could decide whether or not to seek medical care and then which providers and technologies to use. For medical care as for other services, consumers consider both cost and quality when making such decisions. If the cost of one health plan or technology were lower than others, a person would weigh the benefits along with the costs of each in choosing among them.

Evaluation of medical technologies currently has many deficiencies. As previous OTA reports have pointed out, information about new and existing technologies is not systematically developed (200,201,208). Even medical experts often lack the knowledge required to compare alternative technologies. The information that is developed may

not be disseminated in such a way that it reaches the providers and consumers who could use it. The quality of care now delivered is also far from perfect. Although quality is difficult to measure and evaluate, it is clear that deficiencies now exist and that improvement is possible (see ch. 4).

Information about alternative medical technologies will continue to pose problems. The specific concern of this chapter is not with the entire problem of information, but with the changes that might occur if greater price competition were introduced. Would the information needs of consumers differ under greater cost sharing or greater plan competition? How much of that requisite information is currently available and what would a more competitive environment be likely to generate? Different incentives to develop information and the methodological problems of doing so are analyzed. The final sections of the chapter summarize the changes that are likely to take place and discuss private and public sector approaches to the problem areas that have been identified.

## CONSUMER DECISIONS IN THE PRESENT CONTEXT

### Selection of Health Insurance Plans

Although the vast majority of people in the United States have health insurance, relatively few are presented with a choice among plans. In 1977, almost 90 percent of U.S. workers had employment-based group health insurance, but only 18 percent (11 million) were offered a multiple choice of plans (84,253). The common practice is that an employer or union develops an insurance package, which is then offered to employees. The Health Maintenance Organization Act (Public Law 93-222) requires employers with 25 or more employees that provide health insurance to offer a federally qualified health maintenance organiza-

tion (HMO) if there is one in the area. Of employees who had options, 7 million (11 percent of all workers) had an HMO as one of their options. The implication of these statistics is that choice of coverage is greater because of that legislation (84).

Medicare beneficiaries—people aged 65 or older, disabled people, or end-stage renal disease patients—have some limited options. They can elect coverage under Part A (institutional services) and/or Part B (physician services) with the benefit coverage determined by Federal legislation and regulation. About two-thirds of Medicare beneficiaries also purchase supplementary private in-

insurance (see app. F). Only about 2 percent are enrolled in HMOs.<sup>1</sup>

Medicaid eligibles usually have little or no choice among health plans. Although the Federal Government requires certain minimum benefits and minimal patient cost sharing, the States have some discretion to set benefits, eligibility, and payment for providers. Less than 2 percent of Medicaid eligibles belong to HMOs (61). The uncertain length of Medicaid eligibility conflicts with HMOs' commitment to provide medical care for a specified period, and the dispersion of people eligible for Medicaid makes marketing difficult.

Across all age groups, an estimated 26.6 million people representing 2.6 percent of the civilian noninstitutionalized population, had no public or private health insurance coverage in 1977 (135). Lack of coverage is highest among young adults, nonwhites, and people in rural areas. In the families of uninsured people, 43 percent of the other family members had no insurance (135). About 8 percent of the employed lack health insurance coverage, mostly people working in companies with low wages, on a part-time or self-employed basis, in seasonal employment, or in companies with health insurance policies that have waiting periods (49).

Consumers have limited understanding of many aspects of their insurance, particularly health care expenses, cost of coverage, continuance provisions, and types and scope of benefits (9).

This limited knowledge may be reasonable in the present context, in which people have few choices to make about health insurance coverage. People who have no choice among plans or who do not intend to change their coverage have little use for information about health insurance. In the survey that found a low level of knowledge, 40 percent of the respondents said that existing insurance information was sufficient and only 7 percent wanted more information (9). By contrast HMO enrollees, who have a choice of plans, have consistently been more knowledgeable about their

coverage than patients of solo fee-for-service physicians (159).

As one would expect, the more complicated the benefits and cost-sharing provisions, the less accurate is people's knowledge. A survey of consumers in several localities found about 90 percent were accurate about whether or not they had private insurance and coverage for hospitalization and dental care (167). Approximately 80 percent of families with first-dollar coverage for outpatient medical services knew they were covered. But only 50 to 60 percent of the families were aware that outpatient drugs and physician services were covered if a deductible was required. It is noteworthy that people's reports of their share of expenses averaged within 10 percent of the correct answer. Although the study did not correlate consumers' perceptions with the use of services, this finding raises the possibility that people have more of a working knowledge of their coverage than is conveyed by the survey responses.

### Patient Initiation of Care and Selection of Technologies

It has long been observed that patients rely on physicians for advice about the use of medical technologies, and this delegation of responsibility has been attributed to the consumer's lack of medical expertise (7).

Although most people clearly do not have the technical knowledge of medical professionals, they do have some knowledge about and take a more active role in determining the use of some kinds of technologies. Through experience, consumers can become reasonably well informed about technologies that they use frequently, such as normal deliveries, most dental caries repair, preventive care, and drugs for common and chronic conditions (211). Pauly estimated that such services may account for 25 percent of all medical expenditures. There are other services, such as appendectomy, that an individual uses rarely but that physicians perform frequently. In addition to their physicians' advice, people may gain considerable knowledge about such technologies from other patients. People are more dependent on physicians for guidance about services that both individuals and physicians use infre-

<sup>1</sup>ID. N. Use and D. Sawyer, *The Medicare and Medicaid Data Book, 1981. Health Care Financing Program Statistics* (Washington, D. C.: Health Care Financing Administration, Office of Research and Demonstrations, April 1982).

quently, such as experimental procedures (63, 211).

Legal requirements that physicians and other providers be licensed are at least partly intended to compensate for consumers' ignorance by certifying the competence of these professional advisers. Similar limits on patients' use of technology are imposed by requirements that only physicians may prescribe certain drugs or admit patients to hospitals (63).

Despite these practical and legal constraints, people exert substantial influence over the use of

technologies. They may delay care or not seek it for self-limiting conditions. If they decide to initiate care, they choose the physicians or organizations to provide it. Patients decide whether or not to comply with the physician's recommendation, such as drug therapy for hypertension. Patients' discussions with physicians may influence physicians' ordering of ancillary technologies and admissions to hospitals. Patients also evaluate the care that they receive and, if dissatisfied, may switch providers. The factors that people use to evaluate their medical care include technical standards but also encompass interpersonal aspects and accessibility (see ch. 4).

## INFORMATION REQUIRED UNDER INCREASED COMPETITION

People now routinely make many decisions about insurance coverage and medical care. The intended effect of competitive strategies is to make people more sensitive to costs in the decisions that they make about health plans or medical care. Under increased competition, people would consider the risks and benefits of alternative insurance coverage and medical services as they do now. What would differ is the extent to which cost enters into their decisions.

Would different or supplementary information be needed for the more cost-conscious decisions that people would be expected to make? It is useful to bear in mind that, in theory, not everyone needs full information for a market to function smoothly; a minority of well-informed consumers, whose exact number is left undefined, can influence other consumers and the direction of the market (79,211).

### Selection of Health Insurance Plans

For consumers to weigh cost more heavily in selecting coverage requires that such information be available about each plan. This cost information falls into three categories: 1) the annual cost of insurance premiums, 2) the annual out-of-pocket expenses likely for services not paid by the plan, and 3) the sum of these two categories, total expenditures. The information would have to be presented in a standard or understandable way

across plans so that people could make comparisons.

Consumers' other information needs would depend on the differences that would exist among plans (see table 7). Although all of the competitive proposals call for comprehensive benefits to be covered, what is included in comprehensive benefits is open to interpretation (see ch. 2). Some of the proponents of greater competition would permit considerable variation among plans (170, 211). Others would have minimum standard benefits clearly defined and required for a plan to qualify for participation (79). All proponents would permit plans to offer optional coverage of services, such as vision care or dental services, that were not included in the comprehensive benefits. Supplementary coverage could also be offered for the out-of-pocket expenses under greater cost sharing. To the extent that the basic or optional benefits varied across plans, meaningful comparisons would require that the differences in coverage and their cost implications be stated.

For health insurance as for other purchases, consumers would consider the different benefits along with the different costs of alternative plans. Some of the different costs might stem from different styles of practice that do not have significant implications for quality of care. Such differences in practice styles might interest consumers

Table 7.—Information Needed by Consumers for Decisions Under Increased Competition

Decision to be made	Type of information needed			
	costs	Benefit coverage	Quality of care	Technology information
<b>Selection of health insurance plan</b>				
If comprehensive benefits standard:	Premiums, out-of-pocket expenses likely	Benefits covered	Any quality differences that affect health	
If no basic benefits:	Premiums, out-of-pocket expenses likely	Benefits covered	Any quality differences that affect health	
For supplementary coverage to basic benefits:	Premiums, out-of-pocket expenses likely	Benefits covered		—
<b>Limitation of medical care</b>				
With greater patient cost sharing:	Cost-sharing provisions of insurance, charges likely	Benefits covered		Distinction between self-limiting and other medical conditions, appropriate preventive schedule
In comprehensive care organization:	Cost-sharing provisions of plan	Benefits covered		Appropriate preventive schedule
<b>Selection of provider or technology</b>				
With greater patient cost sharing:	Cost-sharing provisions of insurance	Benefits covered	Competence of provider	
In comprehensive care organization:	Cost-sharing provisions of plan	Benefits covered		

SOURCE: Office of Technology Assessment.

but would not be vital for them to know beforehand. If they were dissatisfied, they could switch plans during the next open enrollment period. The experience of satisfied enrollees could spread by word of mouth, and enrollment might rise in plans considered desirable. A similar situation could pertain for some of the dimensions of quality that consumers value, such as interpersonal aspects and accessibility. People could learn from their own experience and that of others and gravitate to the plans that they preferred.

Of primary concern are any differences among plans that would harm patients' health by increasing morbidity, or impairing their ability to function or even raising mortality rates. Consumers today face problems in assessing providers' technical standards of quality and minimum levels of competence. Would these problems be changed under increased cost consciousness?

For insurance policies with greater cost sharing, the direction of the concern about providers' use of technologies would continue to be with overprovision (see chs. 3 and 4). Providers would

have no apparent incentive to recommend too few services and might reduce inappropriate use in an attempt to deliver care at a cost competitive with others. With the same retrospective payment methods (fee-for-service to physicians and charge- or cost-based to hospitals), it is possible that providers collectively would generate additional use to maintain their income levels. Concerns about overprovision arise particularly in the area of catastrophic expenses (see ch. 3).

For the competitive strategy that emphasizes enrollment in comprehensive care organizations, the direction of the concern about providers' use would be with underprovision. With a prospective payment per enrollee and standard comprehensive benefits, providers could achieve lower costs by recommending fewer services than appropriate (see ch. 4).

As chapter 4 has discussed in depth, assuring that people receive medical care of acceptable quality will continue to pose problems under increased competition. The different direction of the effects likely under alternative strategies suggests

that different emphases would be advisable. The issue that remains is the appropriate role for consumers and other groups. To what extent is it reasonable that consumers inform themselves about the technical quality of care delivered by alternative plans and make enrollment decisions based on that knowledge? And to what extent is it reasonable that the medical community or Government ensure that all plans offer at least acceptable levels of quality?

### Initiation of Care

People will also consider the costs and benefits of seeking medical care. To predict the cost, they will require information about their insurance coverage—both the kinds of services covered and any cost-sharing provisions—and about providers' charges for the kind of care being considered.

For enrollees of comprehensive care organizations with minimal cost sharing, cost will provide little deterrent to their initiating care, and benefits will cover most services including preventive ones.

Under greater cost sharing, cost would pose more of a barrier. People in plans with greater cost sharing would need to be better informed about the appropriate circumstances for seeking care so that they did not avoid or delay medical care when to do so would harm their health. They would have to distinguish self-limiting conditions (such as the common cold) from conditions (such as beta hemolytic streptococcus infections) that can have worse consequences (rheumatic fever) if care is delayed.

Most health insurance now excludes preventive technologies. Under greater cost sharing, people would continue to need information about appropriate preventive care, both the kinds of technologies that are effective and the schedule recommended. Then as now, information would be particularly valuable for pediatric and prenatal care. These areas have many effective preventive and therapeutic technologies, and long-term problems for the individuals and for the society can result from their disuse. Vaccines against infectious diseases such as poliomyelitis and measles can prevent crippling, mental retardation, and even death. If untreated, otitis media (middle ear infection) can result in hearing loss or mastoiditis

(infection of the mastoid cavity of a skull bone), but antibiotics can prevent those complications.

### Selection of Providers and Technologies

Consideration of costs in selecting providers and technologies would also require that consumers know the benefit coverage and cost-sharing provisions of their health insurance, as well as the charges for the alternative providers and technologies.

The cost of particular services would be less important to members of comprehensive care organizations with minimal cost sharing. Once a member has made the decision to seek care, the organization would guide the use of particular providers and technologies.

Under greater cost sharing and more traditional insurance arrangements, consumers would make some of the decisions and rely on physicians to make or guide others. Seeking care may entail the choice of a provider or technology. People with situational mental health problems may choose among psychiatrists, psychologists, or mental health clinics. Selection of a practice for maternity care may involve a choice between an obstetrician or midwife and among hospital admission, do-not-admit hospital care, or birthing center for normal delivery. When a person is under medical care, instances will arise when the patient can influence the provider's decision about admission to hospital or ambulatory care, the use of ancillary tests, or even therapy.

As with the selection of health plans and initiation of care, the concern is that consumers out of ignorance would choose incompetent providers or ineffective technologies for a given medical condition. This problem exists in the current context. Under greater cost sharing, it is possible that more sensitivity to cost would lead consumers to choose care that was less expensive but ineffective or harmful. As with the other choices, the issue is the extent to which consumers can deal with these problems by having more information. And to what extent is it most appropriate for the medical community, other parts of the private sector, or the Government to structure the system or guide consumers' and providers' decisions so that these problems are avoided?

## AVAILABILITY OF CONSUMER INFORMATION

### Current Sources of Information

Present consumer information about health insurance plans and medical technologies in large measure reflects the kinds of decisions that people make. Most people do not know the costs of their health insurance, as one would expect when they do not bear the full cost and usually have no choice among plans. The charges of individual physicians, hospitals, and other providers are not routinely published. In fact, court decisions have only recently begun to remove restrictions on physicians' advertising (see app. G).

Similarly, there are few comparisons of the benefit coverage and costs of alternative plans. A private third-party payer usually produces one pamphlet for all the coverage options within a plan. With the exception of pamphlets for the elderly, few private insurers target their information to population subgroups. The pamphlets present neither information about out-of-pocket expenses nor clear descriptions of conditions of coverage and scope of benefits.

A recent Blue Cross/Blue Shield booklet for the Federal Employees Health Benefits Program (FEHBP) illustrates common difficulties (175). Maternity benefits, for example, are described in several different sections about hospitalization or physician visits. Scope of coverage and out-of-pocket costs are confusing. Although the booklet states that the plan would pay hospitalization in full, there is a copayment of \$25 per day for the first 10 days of each admission. The text refers to reimbursement of usual, customary, and reasonable charges, but provides no specifics about fees. Also unclear are eligibility and coverage for premature infants as well as the procedures and costs of switching plans (175).

People considering a change in health insurance have obtained information from a variety of sources (9). Those under age 62 have drawn information primarily from employers or unions (49 percent), private insurance companies (20 percent), and families (16 percent). People over 62 have relied on Social Security offices (30 percent), friends (25 percent), and private insurance com-

panies (21 percent). For the total population, more people received information through personal contacts (23 percent) and booklets (20 percent) than through any other media.

### Deterrents to Providing Consumer Information and Some Exceptions

The dearth of consumer information about health insurance plans and medical technologies reflects characteristics of the present medical care system, the nature of information in general, and restrictions on providing information.

With the limited choices now available, most people would have no occasion to use more information. Few employers offer their workers a choice of health insurance plans, and the number of people who insure themselves individually is small. In light of the limited market for the information and the substantial expense of compiling it, potential publishers have no incentive to undertake comparisons of plans.

An exception is FEHBP, under which Federal employees may choose their health insurance plan from several alternatives (see app. C). The information that has been prepared by each plan and distributed by the Federal Office of Personnel Management (OPM) has not lent itself to comparisons among plans. The brochures have neither compared alternative plans nor presented each plan's benefits or costs in a standardized way. Another problem relating to information is that some prepaid groups have complained that OPM has not distributed adequate information about their plans. Their concern was that OPM'S limited distribution of individual plan booklets, coupled with the emphasis on the Government-wide plans such as Blue Cross/Blue Shield and Aetna in OPM'S summaries, put the prepaid groups at a disadvantage.

*Washington Consumers' Checkbook*, a magazine published by a nonprofit organization, illustrates that information for consumers may be generated when there is a market for it. Since 1979, *Washington Consumers' Checkbook* has

prepared an annual guide to Federal plans in the Washington, D. C., area. Unlike OPM literature, the guide draws conclusions about the plans. It compares plan benefits, special features such as dental coverage or customer service, eligibility, premiums, and out-of-pocket costs. The publication has been widely marketed in the Washington, D. C., area and is available in Federal personnel offices. The results of the comparisons may have influenced employees' selections. During the 1980 open enrollment period, a plan that was ranked highly in terms of benefits for costs increased its Washington enrollment by 120 percent, compared with less than 20 percent nationally (145). The magazine has also conducted local surveys of nursing homes, HMOS, and hospitals to assist consumers in choosing plans and providers.

Stimulated by recommendations from the General Accounting Office and perhaps by the example of *Washington Consumers' Checkbook*, OPM has experimented with booklets summarizing the plans. During the recent open enrollment period, OPM'S materials to each employee included charts comparing the premiums, benefit coverage, and cost-sharing provisions of each plan. No estimates were made of the out-of-pocket expenses under each plan.

The nature of information may also inhibit its provision in medical care as in other fields (205). The entity that develops the information may not be able to retain exclusive control over its use. Once comparisons of plans or providers are made and printed, the publication is easily passed around and shared by many people. The original source of the information may therefore have difficulty selling enough copies to make the undertaking profitable.

Governmentally funded agencies have developed information about local providers. The Northern Virginia Health Systems Agency (HSA) published a directory of information about local physicians (see app. G). It lists each one's credentials, services provided, and insurance and billing practices. No fees are included. Several HSAS in the Washington, D. C., area also cooperated to produce data about the volume of cardiac surgery in local hospitals. The association that was found between low volume and high mortality

rates prompted measures to regionalize facilities, especially for pediatric cardiac surgery (174).

Both legal and professional prohibitions have restricted the provision of information about medical providers and technologies. Although these policies are changing to permit advertising, their existence in the past helps to explain why providers themselves have not publicized their fees and services.

The Federal Government originally prohibited FEHBP plans from advertising. That prohibition was dropped in the late 1960's, and in recent years participating plans have notably increased their advertising (see app. C).

In the case of optometric examinations, restrictions on price advertising have been associated with higher prices. In States that banned price advertising for optometrists and opticians, prices for similar services were 17 percent higher than in the States that permitted such advertising (86). These results support the contention that price information helps consumers to search more effectively for lower prices. This example also pertained to vision services, an area less likely to be covered by health insurance.

Related to legal restrictions is access to data that have been collected. Several professional groups now collect data about the performance and credentials of providers. The Joint Commission on the Accreditation of Hospitals tests the accuracy of hospital laboratory tests on blinded samples. In the course of utilization review, Professional Standards Review Organizations (PSROS) compile data about the use of services and outcomes of patients. Hospitals know whether or not their staff physicians are board certified.

The confidentiality of such data varies by State. Information about board certification is not generally available, but California hospitals report the board certification of their physicians to a public commission. Maryland legislation has made PSRO data nonconfidential. The Baltimore City PSRO has combined its data with those from the Maryland Cost Review Commission to develop profiles by provider on fees, length of stay, and patient outcome. Area employers and unions in turn have used this information to develop

health insurance packages and to advise workers about providers (174) (see app. H).

### **Methodological Problems of Developing Information**

Aside from the incentives inhibiting consumer information, methodological problems plague the development of accurate comparisons of plans and providers.

There are inherent problems in comparing the cost of health plans. The use of specific benefits and the out-of-pocket costs incurred depend on the characteristics of the individual or family. Statistics about average costs may therefore have limited usefulness to a particular person. More sophisticated estimates might be possible although they would certainly be more expensive to cal-

culate. Cost by age-sex category or a complete assessment of risk status could give a person a better indication of the direct costs likely.

Comparisons of hospitals or physicians also pose difficult problems. Undesirable outcomes, such as mortality or infection rates, may be misleading because of small sample sizes or differences in the case mix of their patients. Chapter 4 has discussed the tenuous relationship between structural indicators of quality (such as board certification) and desirable health outcomes. Cost comparisons face problems common to developing any such index of services. A provider may have higher prices for some services and lower prices for other services. The ranking of providers depends on the services selected for the index and the method of weighting their prices.

## **IMPLICATIONS FOR POLICY**

### **Private Sector Provision of Information Under Increased Competition**

The current paucity of consumer information does not necessarily imply that needed information would be unavailable in a more competitive situation. The different choices that consumers would be called on to make and their heightened sensitivity to price in such a situation might stimulate the development of new information.

If consumers have more interest in the cost of health plans and more choice among alternatives, both the plans and other private organizations may respond by providing cost information and plan comparisons. In the course of their operations, third-party payers currently assemble information on providers' charges and use of technologies. If competition on the basis of price intensified among plans, insurers might be more likely to share their information with the public to attract customers. More private sector activities such as *Washington Consumers Checkbook* might also be stimulated by increased consumer choice and interest in costs and supporting information.

On the other hand, consumer information has not appeared in some areas where one would have expected it. It is puzzling that third parties have not publicized providers with high claim rates to discourage overuse (211). Information was not developed for the elderly about policies to supplement Medicare, despite the fact that elderly consumers constitute a large market and bear the full cost of those premiums (see app. F).

If consumers become more interested in the cost of providers and technologies and providers compete on the basis of price, medical professionals, hospitals, or their professional associations may themselves publicize information about charges. In the absence of advertising restrictions, vision care providers advertised their prices, and prices were lower (86). The case of vision care has many similarities with greater cost sharing, since eyeglasses and nonphysician services are less likely to be covered by health insurance.

There is no direct information about whether greater cost sharing leads consumers to search for lower priced care. With greater cost sharing, people would have more incentive to search for lower

cost providers and to become more knowledgeable about services, such as primary care, over which they have more control (63). Consumers would also have more financial reason to seek second opinions about potentially costly procedures, such as surgery. But greater cost sharing might deter consumers from seeking second opinions (58,86), because the consumers would have to pay the additional cost of the second consultation.

Business, labor unions, and coalitions of purchasers of health insurance have become increasingly active in efforts to contain medical costs. Although their informational activities have mainly involved educating workers about health insurance benefits, these groups have expressed interest in developing data bases and informing people about medical technologies (137). The cooperation of employers and unions with the Baltimore City PSRO indicates the potential for developing and disseminating information to workers (see app. H).

### **Role of the Public Sector Under Increased Competition**

The role of Federal, State, or local governments in providing consumer information would depend on their responsibilities for administering greater competition among plans and consumers' selection of plans. It would also depend on the type and quality of information that would emanate from the private sector.

Both PSROS and HSAS could develop information about specific providers. PSROS have the data (if confidentiality problems could be surmounted), and HSAS have the community perspective. Methodological difficulties of comparisons would remain and would need to be addressed so that information would not mislead consumers. Because good evaluations can be expensive, it would be important to determine needs and priorities carefully.

The problems that arose with medical insurance to supplement Medicare call into question the ability of the private sector to provide adequate information about insurance plans to the public (see app. F). physical limitations have hindered many elderly people from gaining information be-

cause they have had difficulty reading brochures or shopping for plans and providers. Aside from these special limitations, however, there were problems about the availability of information. The complexity and variation of the supplementary insurance policies made them difficult to compare. No private groups, such as Washington *Consumers' Checkbook*, came forward to offer objective comparisons among plans. Although elderly people had an incentive to consider cost because they were paying the total premiums, they often bought duplicate coverage and misunderstood the benefit limitations.

The backdrop to this situation is the complexity of Medicare coverage itself. Medicare benefit coverage and cost sharing have bewildering variations, and policies to supplement the gaps have been correspondingly complex. Therefore, the problems and experience with supplementary insurance to Medicare may not apply to plan choice in which a minimum level of comprehensive benefits is required and standardized, as Enthoven has recommended (79).

The response to the problems with supplementary medical insurance has been the adoption of voluntary Federal certification that operates in conjunction with State regulation (see app. F). In States that do not have an approved regulatory program, insurers may submit policies to the Federal Health Care Financing Administration (HCFA) for review. Certification will be granted if the policy meets minimum standards for benefits, loss ratio, disclosure, and administrative procedure. This approach is one of excluding policies that do not meet the minimum criteria. In 1979, for example, four States prohibited policies against dread disease (207).

In regulating information about supplementary policies, States have employed two other strategies, standardization of benefit coverage and information disclosure (see app. F). Wisconsin pioneered these approaches. In 1978, it required that supplementary Medicare policies conform to the standards for one of four designated categories. Standardization is combined with the provision to consumers of information to explain the categories. Wisconsin has periodically published representative prices to facilitate comparisons of

**plans.** Other States, notably California and Massachusetts, use variants of the standardization approach. A common effect, clearly discernible in Wisconsin, is that the number of active insurers drops substantially after the market is controlled.

Many States have disclosure requirements for these supplementary policies, and some have them for all health insurance sold to the elderly (see app. F). Some States require that the benefits and gaps in coverage be listed. Wisconsin alone mandates that a disclosure form be provided at the time of sale, rather than with the delivery of the policy. Few States require the use of consumer information booklets. About half of the States, as well as HCFA and the National Association of Insurance Commissioners, have such brochures available.

Congress has mandated that HCFA survey elderly insurance consumers in six States that have taken different regulatory approaches (see app. F). The diversity among States could serve as natural demonstration projects and suggest desirable approaches for any future Federal involvement in administering greater competition among plans for the entire population.

The design and operation of FEHBP also provides much relevant experience. Comparative information about plans has undergone great improvement recently. Comparing plans remains difficult, however, because of the diversity in benefit coverage and cost-sharing provisions.

Possible models for the Federal Government's administrative role in plan competition are its regulation of the disclosure of financial information through the Securities and Exchange Commission (SEC) and the Truth-in-Lending laws (79). Since the 1930's, SEC has required basic standardized, comparative financial information of public companies. The Government does not generate the information itself, but rather requires the individual companies to do so. Information disclosed by companies is reviewed by SEC for completeness and fairness under the threat of severe civil and

criminal penalties for false or misleading information (see app. I).

The Truth-in-Lending laws of the 1960's and 1970's have similarly attempted to enhance competition among lenders and to promote the informed use of credit by standardizing terminology in the credit cost area. Such laws are regulated by the Federal Reserve System (see app. I).

Using these existing models, the Federal Government could require provide= to generate basic, minimum, and comparable information, such as premiums, likely out-of-pocket costs, and benefits covered. It would also be possible to require information about indicators of quality or practice style, such as ambulatory and hospital utilization rates, disenrollment rates, and board certification of physicians. As with SEC, providers could have to attest to the accuracy and completeness of submitted data or be subject to civil and criminal penalties (see app. I).

Especially in the case of SEC, a problem encountered with regulation of information disclosure is that the costs of generating the information have sometimes become prohibitive for the smaller providers (see app. I). A possible implication in the medical care area is that smaller provider groups and plans may be at a comparative disadvantage if information disclosure is mandated.

These models relate to insurance plans and do not address information needs regarding use under greater cost sharing. Medical experts as well as consumers now lack knowledge about the effectiveness of many technologies and meaningful measures of provider competence. These deficiencies would persist under greater cost sharing. What would differ is the importance of consumer knowledge about initiating use. With price acting as more of a deterrent, people would exercise more discretion about seeking care. This change implies a need for consumers to improve their knowledge of effective preventive technologies and their ability to distinguish self-limiting from other conditions.